MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

REPAIR OF Right Inguinal HERNIA with plug and patch

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that not guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be:

(Description of operation or procedure in layman's language)

The surgical procedure of repairing a protrusion of an organ or tissue through an abnormal openin

which is to be performed by or under the direction of Dr. Bolton, D.

On As scheduled (date)

2. I request the performance of the above - named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below - named medical facility, during the course of the above - named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below - named facility.

4. Exceptions to surgery or anesthesia, if any, are:

(If none, so state)

5. I request the disposal by authorities of the below - named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions.

a. The name of the patient and his\her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PROVIDER: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(Signature of Counseling Provider)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Scott Coffin — X [signature] — 1/9/04 0700

(Signature of Witness, excluding members of operating team) (Signature of Patient) (Date and Time)

SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent): I, sponsor/guardian of understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor or Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, middle, grade; date; hospital or medical facility)*

(FULL NAME & REGISTRATION NO.)

** Mire el reverso para el espanol **

"This is a translation of an English-language document provided as a courtesy to those not fluent in English. If differences or any misunderstandings occur, the document of record shall be the related English-language document."

"La siguiente es una traduccion de un documento en ingles que se provee como cortesia a los que no hablan o son fluentes en ingles. Si existe alguna deferencia o mal entendido, el documento original en ingles es el valido."

ALLEN, ANTHONY
40428-053
MCFP SPG MO
DOB 3-2-64

DO NOT THIN

Institution Form No. SPG-8
Revised 1-30-97
Medical Center for Federal Prisoners, Springfield, Mo.

)OCUMENTO

CARTA DE SOLICITUD
PARA LA ADMINISTRACION DE ANESTHESIA, PARA OBTENER TRATAMIENTOS QUIRURGICOS, O PARA OTROS PROCEDIMIENTOS MEDICOS

MEDICO

A. IDENTIFICACION

.. Operacion a Procedimiento (Tratamiento)
(Ver al reverso)

B. DECLARACION DE SOLICITUD

1. Me han explicado completamente la necesidad y el caracter (clase) de tal operacion (procedimiento quirurgico) o ratamiento medico (procedimeinto). Igualmente, me han explicado metodos alternativos de tratamiento; y entiendo los riesgos y las complicaciones que pueden ocurir. estoy de acuerdo, que no se me ha hecho ninguna garantia con respecto a los resultados de tal operacion o procedimiento. Entiendo que la operacion o tratamiento medico es el siguiente.

La cual sera ejecutada por/con la dirrection del Dr. (Ver al reverso)

En (Ver al reverso) fecha

2. Solicito la operacion o tratamiento medico, mencionado anteriomente, y ademas, cualguier otra wperacion o procedimiento que se encuentre necesario o deseable, conforme la opinion del cuerpo medico de la institucion medica, aqui nombrada; mientras que se ejecute tal operacion a tratamiento.

3. solicito la administraciion de cual anestesia se considere necesaria o recomendable, conforme la opinion de los medicos profesionistas de la institution medica, aqui nombrada.

4. Contradicciones o exclusiones, a esta cirugia o adminstracion de anestesia son, (si las hubiera): (Ver al reverso)
(si ninguna, declarelo as!)

5. Solicito que las autoridades de la institucion medica, dispongan el destino final de los tejidos, o partes/miembros del cuerpo, que sea necesario extirpar (remover).

6. Entiendo que es posible, que tomen fotografias y peliculas de esta operacion; y que se pueden usar por raxones de entrenamiento o instuuccion, con estudiantes y empleados nuevos de esta o otra institucion. Doy permiso para que tomen estas fofografias y peliculas durante la operacion; y para que personas autorizadas puedan observar la operacion, de acuerdo con las siguientes condiciones:

a. Esta prohibido, usar el nombre del paciente o do su familia, para identificar tal pelicula o fotos.
b. dichas peliculas y fotos, se usaran unicamente por razones de estudio medico/dental y para investigaciones escolares de la medicina.

C. FIRMAS (Ver al reverso)

1. CONSEJERO: He consejado a este paciente sobre la necesidad y el caracter del procedimiento(s) anticipado, los riesgos, y el resultado posible de tal procedimiento(s), segun como esta aqui escrito anteriormente.

2. PACIENTE: Comprendo la necesidad y el caracter del procedimiento(s) anticipado, los riesgos, y el resultado posible de tal procedimiento, segun como esta aqui escrito anteriormente; y solicito tal operacion o procedimiento(s).

3. TUTOR O PERSONA RESPONSABLE: (Cuando el paciente sea menor de edad, o no sea capaz de dar su consentimiento): Yo, (Ver al reverso) Tutor/Person Responsable por (Ver al reverso) entiendo la necesidad y el caracter del procedimiento(s).

(FIRMA - VER AL REVERSO)

NSN7540-00-634-4176 600-108

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	SAME DAY SURGERY ASSESSMENT
1/9/04	Mode of Arrival: Ambulatory ✓ Wheelchair _____ Gurney _____
0705	Reason for Admission: Repair of (R) Inguinel Hernia w/ plug & patch
	Medical/Surgical History: See H+P
	Allergies: NKDA
	If Allergic, Reaction:
	NPO since 1-08-04 VS: BP 139/81 P 70 R 20 T 96.1 SaO2 99 % RA
	Height 6'1 Weight 198
	Pain Assessment
	Are you Having Pain? Yes (No) 0 1 2 3 4 5 6 7 8 9 10
	Location Intensity Frequency Duration
	Pre-op Teaching: Handout given: ✓ Post-op Teaching: Handout given: ✓
	Verbalizes understanding of pre and post-operative teaching:
	Permit Signed: ✓ Bracelet identification ✓ To OR via gurney
	Discharge from PACU: (*See PACU Record*) Signature S. Robinson CNA
	DISCHARGE FROM 1-4:
	Mode of Transportation: Ambulatory ____ Wheelchair _____ Gurney _____
	Condition on Discharge:
	Post op Teaching: (*see Discharge Summary*)
	Admission to 1-4: (*see Nurses Note*)
	INDIVIDUAL EVALUATION/TREATMENT/MANAGEMENT PLAN (see on back)

PATIENT'S IDENTIFICATION (*Use this space for Mechanical imprint*)

ALLEN, ANTHONY
40428-053
MCFP SPG MO
DOB 3-2-54

RECORDS MAINTAINED AT		
PATIENT'S NAME (*Last, First, Middle initial*)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	INDIVIDUAL EVALUATION/TREATMENT/MANAGEMENT PLAN
	CONTINUATION SHEET
	Goal Statement: PATIENT EDUCATION/DISCHARGE PLANNING for SAME-DAY SURGERY:(*name of procedure)*
	The patient will verbalize/communicate an understanding of the pre-operative procedure and any medications/treatments and discharge plan before discharge from the hospital as by:
	1. Patient will be able to communicate basic concepts taught.
	2. Patient will demonstrate self-care skills prior to discharge.
	Action Plan: (Include staff name and title)
	A. Assess Educational Level upon Admission.
	B. Collaborate with Other Health Care Members on Educational Needs (Lab, Xray, Pt, Rehab, Physicians)
	C. Encourage and Answer Questions about Procedures and Test.
	D. Evaluate Ability to Perform Self Care.
	3. Post Procedure Pain Assessment
	Are you Having Pain? Yes No 0 1 2 3 4 5 6 7 8 9 10
	Location Intensity Frequency Duration
	Target Date:
	Treatment Review:
	Nurses Signature:

MEDICAL RECORD | CONSULTATION SHEET

REQUEST

TO: Dr Rotton	FROM: Kelly	DATE OF REQUEST:

REASON FOR REQUEST:
39 y/o ♂ c̄ large lt scrotal-inguinal hernia partially reducible

PROVISIONAL DIAGNOSIS:

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULT	
Kelly PA		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72-HRS ☐ EMERGENCY

CONSULTATION REPORT

EXAMINATION:

Pt examined chart reviewed

Imp RIH

Rec RIH

Dictated

[signature]

12 23 03

SIGNATURE AND TITLE	DATE

IDENTIFICATION NO.	ORGANIZATION MCFP Springfield, MO	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION
Allen, Anthony
40425-053

CONSULTATION SHEET
STANDARD FORM 513

NATH L. HILL GRAHAM, M.D. F.A.C.S.
BOARD CERTIFIED, AMERICAN BOARD OF SURGERY

SURGICAL ASSOCIATES OF BRADFORD
51 BOYLSTON STREET
BRADFORD, PA 16701

OFFICE TELEPHONE (814) 368-7125
OFFICE FAX (814) 368-9156

ANTHONY ALLEN 10/27/03

CHIEF COMPLAINT: Large right inguinal hernia.

HISTORY: Mr. Allen is a 39-year old, Jamaican man who has had a slowly enlarging right inguinal hernia for a number of years. It is getting larger. It is no longer fully reducible and has been giving him more pain. He is referred appropriately for hernia evaluation and repair. He moves his bowels well, has no signs of constipation or bowel obstruction. No nausea, vomiting, diarrhea, or any other GI symptoms. He eats well and has maintained a stable weight. He has no difficulty with urination. He also does not have a chronic cough. Source of the history is the patient is the patient and records from FCI McKean.

PAST MEDICAL HISTORY:

MEDICATIONS: None.

ALLERGIES: None.

PREVIOUS SURGERY: None.

MEDICAL PROBLEMS: None.

REVIEW OF SYSTEMS: IN GENERAL: No acute change in weight in the last six months, no change in energy level, no recent fall, and no depression. HEAD: No head injuries, chronic headaches, or seizures. EYES: No difficulty with vision, floaters, or bright lights. EARS: No tinnitus or decreased hearing acuity. THROAT: No difficulty with swallowing, difficulty speaking, or thyroid problems. PULMONARY: No chronic cough, phlegm production, hemoptysis, or shortness of breath. CARDIAC: No chest pain, angina, or history of myocardial infarction. GASTROINTESTINAL: No history of peptic ulcer disease, hematemesis, nausea, or vomiting. COLON: No rectal bleeding, change in bowel habits, or colitis. HEPATOBILIARY: No cholecystitis, cholelithiasis, jaundice, hepatitis, or pancreatitis. RENAL: No nephrolithiasis or hematuria. MUSCULOSKELETAL: No decrease in exercise tolerance or focal weakness. EXTREMITIES: No lateralizing weakness or changes in endurance. HEMATOLOGIC: No easy bleeding, bruising, or serious infections. VASCULAR: No amaurosis fugax, TIA, stroke, no history claudication, skin ulcers, rest pain, or tissue loss.

SOCIAL HISTORY: Patient is at FCI McKean and does not smoke.

PHYSICAL EXAM: GENERAL: Patient is a medium height, large boned, muscular male who is in no acute distress. He weighs 200 lbs. HEENT: He a crew cut and does not wear glasses. EARS, EYES, NOSE, and THROAT have no lesions. NECK: No adenopathy. LUNGS: Clear. HEART: Regular rhythm and rate with no murmurs,

gallops, or rubs. ABDOMEN: Soft and nontender with no masses. Normal bowel sounds. GENITALIA: Normal uncircumcised penis, two descended testes, and a large soft partially reducible right inguinal hernia, which is inguinoscrotal. It extends down covering the testicle. Testicular atrophy cannot be well evaluated because of the bowel loops, which are around this, cannot be completely removed for full evaluation.

IMPRESSION: (1) Large right inguinoscrotal hernia, which should be repaired. Procedure, risks, and benefits are explained to the patient including, but not limited to bleeding, infection, testicular loss or atrophy, recurrence, and pain. He gives informed consent.

(2) He has been having some pain in the teeth along the right side. This is possibly a dental abscess. This needs to be evaluated and corrected if there is an abscess prior to placement of a prosthetic permanent mesh, which could get contaminated by bacterial seeding at the time of manipulation of the dental abscess.

Thank you very much for the consult.

Nathaniel L. Graham, M.D.

NLG/pl

cc: Dr. Beam

Reviewed by D. Olson, MD
Date: 11/25/03

ST. JOHN'S REGIONAL HEALTH CENTER

1235 E. Cherokee ~ Springfield, Mo. 65804-2263

MCK Miller

ANATOMIC PATHOLOGY

Name:	**ALLEN, 40428-053**	Location:	SJ LAB
SJRHC EMR:	090122235	Client:	H MCFP Sensitive L.O.U.
Pt. Fin No:	12857325	Collected:	01/09/2004
Age:	39 Years	Received:	01/10/2004
Birthdate:	03/02/1964	Printed:	02/18/2004
Sex:	Male	Order Physician:	Rotton, D. Brent
		Copy To:	
		Admit Physician:	Rotton, D. Brent

503 D. Hare

SURGICAL PATHOLOGY FINAL REPORT

PATHOLOGY NO:
S-04-000614

Specimen Source
A Hernia Sac, Inguinal, Right

MCFP-#8162
Dr. Rotton

Clinical Information
Right inguinal hernia.

Gross Description
Part A. Submitted in a container of formalin labelled "right inguinal hernia" is a tan membranous fragment of tissue measuring 5.4 x 2.2 x 0.4 cm. Representative sections are submitted in A1.

PR /SDC

Microscopic Description
Microscopic examination was performed.

Diagnosis
Hernia sac, right, inguinal, herniorrhaphy
- fibroadipose tissue consistent with hernia sac.

DeFlorio, Daniel, M.D.
(Electronically signed by)
Verified: 01/12/04
DD /AGS

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
OPTOMETRIST	Dennis Olson, MD, CD	

REASON FOR REQUEST (Complaints and findings)

EYE EXAM : HTN
DM
SUBJECTIVE:

PROVISIONAL DIAGNOSIS

G-2 40

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
D. OLSON, M.D.		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☑ YES ☐ NO

Visual Acuity Distance OD 20/50 OS 20/70 TONOMETRY: OD OS

Near OD .37m OS .37m

External normal TU

Internal

Refraction OD -1.25 20/20
OS -1.25 20/20

Diagnosis myopia

Analysis requires eyeglasses

Plan order eyeglasses

QD x 24 x 6 '04

(Continue on reverse side)

SIGNATURE AND TITLE		DATE
		11/24/04

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.
	FCI McKean	40428-053	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

Reviewed by D. Olson, MD
Date 11/24/04

Allen, Anthony

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 8-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

U.S. Bureau of Prisons
Dental/Medical History Form

1. Are you presently taking any medication? If so, what? yes High Blo...	Yes ✓	No
2. Are you allergic to or have you had a reaction to any medication or drug? If so, what?	Yes	No ✓
3. Have you been under the care of a physician during the past two years? If so, why?	Yes	No ✓
4. Have you been hospitalized in the past two years? If so, why?	Yes	No ✓
5. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you feel very tired?	Yes	No ✓
6. Do your ankles ever swell during the day?	Yes	No ✓
7. Have you ever been treated for a tumor or growth?	Yes	No ✓
8. Have you ever had abnormal bleeding?	Yes	No ✓
9. Have you had any serious difficulty with any previous dental treatment?	Yes	No ✓

Circle any of the following that you have or have had:

Congenital heart defects
Heart attack or heart trouble
Rheumatic Fever
Stroke
Asthma
Anemia(blood problems)
Hepatitis
Thyroid problems
Chronic bronchitis
Venereal disease (syphilis, gonorrhea)
Arthritis
Artificial Heart Valve
Heart murmur
Angina
(High blood pressure) O.I
Heart pacemaker
Epilepsy or seizures
Diabetes
AIDS or HIV infection
Emphysema
Tuberculosis (TB)
Psychiatric treatment
Artificial Joint Prosthesis

Do you have any disease, condition, or problem not listed?	Yes	No ✓
WOMEN ONLY: Are you pregnant?	Yes	No

Name Anthony Allen Reg. No. 40403-052

Institution F.C.I. McKean Date 1-7-94